endothelial stimulant clearances were estimated by autologous plasma haemoglobin clearance[1] and were found to be increased in 6 out of 10 patients with acute leukaemia, 5 out of 11 patients with chronic leukaemia, and in 8 out of 13 cases of Hodgkin's disease. Corticosteroid therapy appeared to make no difference, but those who had depressed clearances had recently been treated with radiotherapy or nitrogen mustard.

The results indicate that certain tumours themselves increase the functional state of the reticuloendothelial stimulant. Increased phagocytosis in patients with carcinomata has been described by Salky *et al.*[2] using reticuloendothelial test lipid emulsion and in Hodgkin's disease by Sheagren *et al.*[3]—I am, etc.

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1 Gabrieli, E. R., and Pyzikiewicz, T., *Journal of the Reticuloendothelial Society*, 1966, 3, 163.
2 Salky, N. K., Di Luzio, N. R., Levin, A. G., and Goldsmith, H. S., *Journal of Laboratory and Clinical Medicine*, 1967, 70, 393.
3 Sheagren, J. N., Block, J. B., and Wolff, S. M., *Clinical Research*, 1966, 14, 360.

Hazard of Self-inflating Resuscitation Bag

SIR,—We would like to report a potentially hazardous defect in unlined self-inflating bags. The danger of insufflation with foam rubber particles from lined bags such as the Ambu is well known (11 October 1969, p. 111), and the Ambu and Ruben valves now incorporate a fine wire filter to prevent this accident. Several unlined bags have become available recently and most, if not all, of these do not incorporate a filter.

During use of the Aga revivator we became aware that flakes of rubber were coming from the inside of the bag (Fig. 1). This bag is manufactured from two hemispheroidal halves bonded together at the equator by a rubber adhesive solution. On cutting open the bag concerned, it was found that excess rubber bonding solution had been extruded from the joint and had run on to the inner surface (arrows, Fig. 2). During repeated use these strips of adhesive rubber had become detached. Extrusion of adhesive was found in 13 of a further 21 bags inspected.

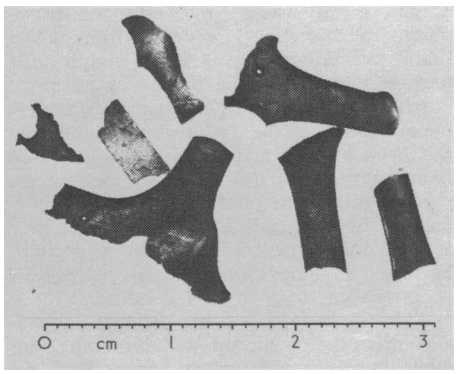

FIG. 1

The Aga company has replaced the faulty bags and now provides, free of charge, nylon mesh filters to fit into the neck of the bag.

We suggest that all self-inflating bag systems should incorporate a filter between the bag and the patient to prevent possible insufflation of debris into the patient's tracheobronchial tree. Such debris could result from bags that were initially faulty or which have suffered deterioration during storage.—We are, etc.,

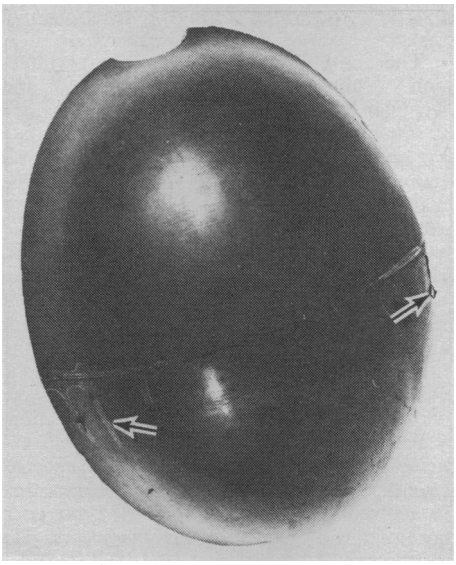

FIG. 2.—Bag everted to show interior surface.

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Oestrogens in Oophorectomized Women

SIR—Dr. S. Gow and Professor I. MacGillivray's article (10 April, p. 73) on metabolic, hormonal, and vascular changes after synthetic oestrogen therapy in oophorectomized women raises several interesting points, not least whether there is a role for such therapy and if so, which hormone. They conclude that the gravity of adverse effects with mestranol far outweighs any beneficial ones. My own investigations into the use of conjugated oestrogens (for example, oestradiol valerate and conjugated equine oestrogens) suggest that these hormones may be used with a far greater margin of safety.

For the past four years I have conducted, through a menopause clinic at the Groote Schuur Hospital, Cape Town, an intensive investigation into the menopause, including the clinical and metabolic effects of oophorectomy and the role of replacement exogenous oestrogen therapy.[1] This study has included several groups and a slightly different spectrum of investigations to those reported by Dr. Gow and Professor MacGillivray. While in agreement in some respects, my own investigations show several significant differences.

Although 50 oophorectomized women received continuous oestradiol valerate therapy for six months none developed any form of thromboembolic disease. One patient developed a superficial thrombophlebitis when the same group was given conjugated equine oestrogen continuously for three months. It would appear that there is a real difference in effect of conjugated and non-conjugated oestrogens on the clotting mechanism, and such relationship is worthy of further investigation.

Oestrogen therapy was confirmed to cause the disappearance of the parabasal cell from the vaginal smear ($p<0.0005$). There was no statistical change in the superficial and intermediate cell counts. It is therefore suggested that the parabasal cell count, expressed as a percentage of the total cells present on vaginal smear, be used as the cytological (and clinical) index of response to oestrogen administration to postmenopausal or oophorectomized patients.[2]

The dogmatic assertion that the prevention of osteoporosis and coronary artery disease by adequate hormone replacement therapy is a recognized medical fact cannot go unchallenged. The evidence is somewhat more convincing in relation to osteoporosis[3] than coronary artery diseases,[4] but far more investigation is still necessary. My own studies have shown the difference in effect of various oestrogens on serum cholesterol after oophorectomy,[5] but even here the complete relationship between oestrogens, cholesterol, and coronary artery disease is still in dispute.

The routine use of oestrogens in all women after the menopause cannot therefore be recommended at this time, not because of the possible adverse effects (which can be prevented), but because of the lack of supportive evidence for the potentially advantageous effects.—I am, etc.,

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1 Utian, W. H., 1970, Ph.D. thesis, University of Cape Town.
2 Utian, W. H. *South African Journal of Obstetrics and Gynaecology*, 1970, 8, 69.
3 Utian, W. H., *South African Medical Journal*, 1971, in press.
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Prescriptions for the Elderly

SIR,—As we are moving towards a greater concern for community care it would seem appropriate to make some investigation into the hardships of the elderly in obtaining medicines and drugs when at a distance from the chemist, and particularly when transport is not very regular, with special emphasis on holidays and weekends.

I fully appreciate that it is the practitioner's responsibility to supply drugs on an "ad hoc" basis when the situation demands it, but there are many categories of drugs which, though essential, do not fall into this category. It is not uncommon to find an elderly husband or wife having to trail the streets in inclement weather, particularly on Sundays, in order to obtain drugs supplied on prescription. This very often results in the well partner becoming ill, with subsequent great stress, not only on the already ill spouse, but on the available manpower—for example, home help, and district nurse.

Many chemists are extremely helpful in this situation and very often go out of their way to deliver a prescription, but of course, this depends entirely on the goodwill of the chemist concerned, and it would seem appropriate to give attention to this rather neglected side of community care.—I am, etc.,

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Blood Clotting and Contraception

SIR,—Dr. L. Poller and others (27 March, p. 705) make a valuable contribution to our knowledge of the effect of hormonal contraceptives on coagulation and fibrinolysis.

The pathogenesis of thrombosis is still obscure, and it is difficult to say whether the changes described in association with the use of hormonal contraceptives predispose to thrombosis. There are no common characteristic changes in the coagulation factors, the fibrinolytic system, platelet aggregation, or adhesiveness in patients with thrombosis. In recent years, however, it has been shown that a normal fibrinolytic activity in the vessel walls is important for counteracting thrombosis. Thus Pandolfi *et al*,[1] showed that the fibrinolytic activity in the veins of the lower leg, where thrombosis is relatively common, is lower than that in veins of the arms. Isacson and Nilsson[2] found the local fibrinolytic activity in the blood and/or vessel walls to be low in 73% of a large series of patients with thrombosis.

In a series of 28 women who had continuously taken 0·5 mg chlormadinone acetate a day—that is, the same hormone and dosage studied by Dr. Poller and others as a contraceptive, we studied the local fibrinolytic activity in the blood also after stimulation by venous occlusion of the arms and legs.[3] In 10 of the patients we determined the fibrinolytic activity in biopsy specimens of superficial veins by means of Todd's method with grading according to Pandolfi. We found the normal response of the fibrinolytic activity to venous occlusion not to be inhibited. The fibrinolytic activity in the vein walls was unchanged. We also found platelet adhesiveness, various coagulation factors, plasminogen. α_2M, antiplasmin, and the urokinase inhibitors to be normal.

In a similar investigation treatment of postmenopausal women with ethinylestradiol (250 μg daily for 10 days) before operation for prolapse significantly suppressed the fibrinolytic activity in the vein walls. It should, however, be pointed out that the amount of ethinylestradiol was about five times as large as that in hormonal contraceptives.

Oestrogenic hormones used in conventional, combined contraceptives and given as lactifuges or for suppressing the blood cholesterol are said to be capable of predisposing to thrombosis. So far as we know continuous use of gestogen as a contraceptive (usually in a daily dose of 0·5 mg chlormadinone acetate) has not given reason to suspect that such treatment predisposes to thrombosis. Further development of this type of contraceptive appears desirable.—We are, etc.,

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1 Pandolfi, M., Nilsson, I. M., Robertson, B., and Isacson, S., *Lancet*, 1967, **2**, 127.
2 Isacson, S., and Nilsson, I. M., *Scandinavian Journal of Haematology*, 1971, Suppl. 16.
3 Nilsson, I. M., Kullander, S., and Astedt, B., *Acta Endocrinologica*, 1970, **65**, 111.

Utus Paste and Termination

SIR,—Having read the article on "Termination of Pregnancy by the Intrauterine Insertion of Utus Paste" by Dr. S. V. Sood (8 May, p. 315) I am surprised by the conclusions that he has reached in his small series of cases. In the light of our present knowledge on techniques of procuring a therapeutic abortion, it is widely accepted that no one method is completely satisfactory. I would suggest that Dr. Sood's figures show that Utus paste has a part to play in this field, provided certain precautions are taken.

The complications of urinary tract infection resulting from catheterization, and irregular vaginal bleeding owing to retained products of conception can both be avoided by correct management. Similarly cervical trauma should rarely, if ever, be seen. The main disadvantage is the serious problem of infection. 14·4% of Dr. Sood's patients had a significant pyrexia requiring treatment. However, every other method of termination has this danger. One effective method of reducing this risk is the prophylactic use of antibiotics with routine evacuation of the uterus immediately following spontaneous abortion. This regimen is justifiable in view of the long-term dangers of pelvic infection.

Failed abortion can be a problem especially if insufficient Utus paste is injected into the larger uterus, or if insufficient time is allowed for the abortion. Dr. Sood does not give full details of his two cases. He mentions one case of maternal death resulting from perforation of the uterus. Of all vaginal methods in use for termination of pregnancy, I suggest that the cannula supplied with Utus paste is the instrument least likely to cause this complication. Also, maternal death has been recorded with every other method of termination.

The Utus paste technique is a useful method for between 12 and 16 weeks gestation. The advantages are as Dr. Sood has stated. Also blood loss is small even after evacuation of the uterus which is a great advantage compared with some other methods.—I am, etc.,

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Emergency Dental Treatment

SIR,—I am sure that most dentists are willing, and, indeed anxious, to attend to any of their patients who suffer a genuine emergency. When a doctor is troubled by dental emergencies it is all too often by a thoughtless patient.

The genuine emergency does have our sympathy. Now that the G.D.C. has relaxed a rule on advertising it is possible for a dentist to display a discreet notice giving his phone number so that his patients can contact him or her at night. With only rare exceptions dentists prefer to attend to any postoperative haemorrhages and these are really the only cases that cannot wait until the next day.

Patients in pain are nearly always seen within a day or so in spite of the fact that the fee for an extraction does not compensate for the disruption caused to normal appointments. Most dentists will do their best and most patients, already booked for appointments, will be tolerant of the patient who is squeezed in to a session.

Emergency services have been tried. In New York there is an Emergency Dental Service advertised in the yellow pages of the telephone book. This scheme is run by the American Dental Association. It is, in fact, a telephone agency that has a rota of dentists who stand by for emergency. The present G.D.C. rules on advertising deter us from suggesting the idea in Britain.

I hope to be able to raise this question with the General Dental Council before the end of this year, and I would welcome any suggestions from doctors in general practice and from casualty officers who can let me have figures to show the need for a service and ideas on how it should be provided.—I am, etc.,

D. N. BARBER

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Manchester 14

Jakob-Creutzfeldt Disease

SIR,—Kuru and Jakob-Creutzfeldt disease can be artificially transmitted from man to other primates and there is evidence that the former is naturally transmissible in man. There have been many admirable clinical and pathological descriptions of Jakob-Creutzfeldt disease under many different titles, but these have naturally been in terms of a "degeneration" of the nervous system and not of a possibly transmissible "infectious" disease. There is need for epidemiological study, including detailed medical and environmental histories, which, from the nature of the disease, must be obtained from informed relatives. Sufficient observations could scarcely be made at a single centre, as the disease is rare and wide collaboration is essential.

I would be keenly interested to act as a centre for the collection of such information, and if those with known or suspected cases of Jakob-Creutzfeldt disease under their care would write to me, something useful might be achieved.—I am, etc.,

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Hiccup

SIR,—The remark in your leading article (1 May, p. 234) concerning the lack of a potent drug to control hiccup prompts me to report my experience with haloperidol in this condition.

Several patients presenting with persistent hiccup were treated with haloperidol. The dosage given was 5 mg t.d.s. orally or parenterally. Patients suffered from lower brain stem disorders, uraemia complicating terminal stages of renal disease or extensive burns, and idiopathic cases where psychogenic factors could not be excluded. The response has been prompt and sustained in all cases. None of the patients treated by me had the regular hiccup manifested in the cases described by Newsom Davis in his excellent article,[1] and no controlled studies were done. However, the impression was that haloperidol is a reliable drug in this condition.

The rationale for using haloperidol was a comparison of hiccup with vomiting, another lower brain stem response. Both reflexes may originate from the gastrointestinal tract and their efferent impulses affect the respiratory muscles. Chlorpromazine is a powerful antiemetic and has (as mentioned in your leading article) a mild effect against hiccup. Haloperidol is more active than chlorpromazine against nausea and vomiting, and its effect against hiccup was therefore thought to be worthwhile trying.

Whether or not this effect of haloperidol is related to its dopamine blocking activity